

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036156

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 002

Registrar's No.

4829

STATE FILE NUMBER

FILED SEP 18 1963

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CASS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MISSOURI		Length of stay in 1b 100 days	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL, KC, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) T. A. GOODMAN		4. DATE OF DEATH Month Day Year AUGUST 31, 1963	
5. SEX MALE	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/30/34
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY TEACHING	
11. BIRTHPLACE (City and state or country) SUMMIT, ARK.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME T.A. GOODMAN SR.		13b. MOTHER'S MAIDEN NAME Juanita Park	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) Yes 6/16/54 to 5/1		16. SOCIAL SECURITY NO. VA HOSPITAL RECORDS	
17. INFORMANT Mrs Eileen Goodman (Wife)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) /INTRARENTRICULAR HEMORRHAGE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ADVANCED PYELONEPHRITIS WITH ABSCESES DUE TO (c) GOUT PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION COUNTY STATE		20g. CITY, TOWN, OR LOCATION COUNTY STATE	
21. VA attended the deceased from 5/23/63 to 8/31/63 and last saw him alive on 8/31/63		22. SIGNATURE Norman K. Kee M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7-1-63	
23c. NAME OF CEMETERY OR CREMATORY Westville Cemetery		23d. LOCATION (City, town, or county) (State) Westville Oklahoma	
24. FUNERAL DIRECTOR Atkinson Dickey Funeral Home		25. DATE RECD. BY LOCAL REG. 9-1-63	
26. REGISTRAR'S SIGNATURE Bessie Smith		27. DATE SIGNED 9-1-63	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

SEP 24 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Forrest D Coldenow

Licensed Embalmer No. 4714

P. O. Address K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.